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FROM THE EDITOR

TOO SMART FOR YOUR OWN GOOD

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"When did you get so clever?"
"When I realized I wasn't as clever as I thought."
—John Connolly, The Infernals

I recently spoke to a potential recruit for a faculty position in one of our academic practices. Although predominantly a clinical position, there was also the opportunity to precept residents and teach medical students. This particular applicant was one year out of residency and unsuccessfully tried to land a fellowship in one of the more competitive procedure oriented specialties. The failure to secure a spot forced him to contemplate what he most enjoyed in medicine. The applicant described that one of the most rewarding parts of his training was developing relationships with patients and their families and impacting their lives. He articulated that desire without hesitation and so clearly that I asked why he had considered subspecializing in the first place? The answer really didn't surprise me.

He described the typical experience of most residents in the United States. The pressure and expectations of fellowship training, as a logical and certain next step that follows internal medicine training, start early. In medical school, students pick electives in areas that they may be interested in practicing 4-5 years in the future. When visiting programs, as part of the residency interview process, they are bombarded with data about how many and which subspecialty fellowships the program's recent housestaff matched into. No residency director ever boasts about how many of their residents chose generalists careers. What information applicants receive regarding graduating residents who chose primary care or hospitalist medicine as a career choice is usually not explicitly stated and merely assumed to be everyone else who didn't get a fellowship.

Then, there is the argument that if you are a high-performing resident with great board scores who is asked to serve as chief resident, you should pursue one of the more competitive fellowships. A resident with that pedigree deserves to pursue cardiology or GI, not general medicine. When I was chief, I was told by one of the GI attending that I "was too smart to do primary care." Back then, I was not as quick with a comeback as now. Actually, I'm not that good now, but what I would say to "not being smart enough" is that I worry that I am not smart enough to be a generalist. If only I could focus on one or a small set of organs and master the associated diagnostic and therapeutic procedure needed. To be sure, my colleagues in GI, cardiology, and endocrine are indeed smart. *We all are*. To prematurely close the thinking of a student or trainee that a generalist career is somehow the lesser road traveled at such an early stage in their career is irresponsible and a disservice to our learners. I make this point to highlight the importance of the work we do as academic generalists and why SGIM is so important.

SGIM members continue to expose our trainees to a broad set of generalist careers, including ambulatory and hospital medicine and geriatrics. SGIM members also occupy the myriad careers that generalists can evolve into, including research, education, and leadership roles. With the annual meeting coming up in May, consider sponsoring a student or trainee to attend. There is no better way to catch the passion of general internal medicine than an SGIM National Meeting.

In addition to the meeting, the SGIM *Forum* represents an excellent opportunity to showcase what a career in academic general medicine looks like and what we care about. This month's *Forum* is a good reflection of the many topics and areas of interest to generalists and what is likely to be presented at the meeting. Dr. DeSalvo continues to address the issue of social determinates of health, the annual meeting's theme, in her President's column on how we can pay to address them. Dr. Allyn and colleagues report on an interdisciplinary collaborative approach to improve the care of patients with chest tubes. Dr. Anderson, et al, provide a conversation calling us to rekindle the age-old practice of bedside rounding. Rounding out the issue are two wonderfully written Breadth and Perspective pieces and a Morning Report.

Share this and other issues with your residents and medical students—they may thank you someday.

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